SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Starmount Life Insurance Company

Product Name: Website APP for UNI APP11	SERFF Tr Num: STAR-128295543	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num:
Sub-TOI: L08.000 Life - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Belle Lucas, Ruston Woolley, Ronetta Andrus	Disposition Date: 05/08/2012
	Date Submitted: 05/03/2012	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name:	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 05/08/2012
	State Status Changed: 05/08/2012
Deemer Date:	Created By: Belle Lucas
Submitted By: Belle Lucas	Corresponding Filing Tracking Number:

Filing Description:

Re: STARMOUNT LIFE INSURANCE COMPANY, NAIC#68985
Universal Application- UNI APP11-web (Website Approvals)

Dear Sir/Madam:

We are pleased to file the above referenced website applications in Arkansas. This filing is a new filing and is being filed without an illustration. The original paper application filing was approved on 11-3-2011 udner STAR-127753216 and we are now requesting approval of the website application. The universal application's purpose was to create an application that can be used for our three major individual life insurance products: Valuelife Gold, Starlife Gold and

SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Selectlife. The Valuelife Gold and the Starlife Gold products are offered on our website, the Selectlife product is not. We request approval of the website application for the Valuelife Gold and Starlife Gold products only. Webshots are attached under the form schedule for your review.

Please contact me if you have any questions at 225-400-9282 or by email bellel@starmountlife.com.

Sincerely,
Belle Lucas
Compliance Specialist

State Narrative:

Company and Contact

Filing Contact Information

Belle Lucas, Compliance Specialist	bellel@starmountlife.com
P.O. Box 98100	225-926-2888 [Phone]
Baton Rouge, LA 70898	

Filing Company Information

Starmount Life Insurance Company	CoCode: 68985	State of Domicile: Louisiana
7800 Office Park Boulevard	Group Code:	Company Type:
Baton Rouge, LA 70809	Group Name:	State ID Number:
(225) 926-2888 ext. [Phone]	FEIN Number: 72-0977315	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	$100 per filing.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starmount Life Insurance Company	$100.00	05/03/2012	58911917

SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/08/2012	05/08/2012

SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/08/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Form	Valuelife Gold web application		Yes
Form	Starlife Gold web application		Yes

SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: UNI APP11-web

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	UNI APP11-web	Application/ Enrollment Form	Valuelife Gold web application	Initial			AR-VLG-Application[1].pdf AR-VLG-1.pdf AR-VLG-2.pdf AR-VLG-3.pdf AR-VLG-4.pdf AR-VLG-5.pdf
	UNI APP11-web	Application/ Enrollment Form	Starlife Gold web application	Initial			AR-SLG-Application[2].pdf AR-SLG-1.pdf AR-SLG-2.pdf AR-SLG-3.pdf AR-SLG-4.pdf AR-SLG-5.pdf

Application for Life Insurance

Starmount Life Insurance Co. • 8485 Goodwood Blvd. • Baton Rouge, LA 70806-7878 • 1-888-729-5433 • www.SayLife.com

For Modified Whole Life Insurance Policy Form No. 32-001; Accidental Death Rider Form No. 97005; Accelerated Benefit Rider 98-010

Main Insured Information

Name John Doe **Date of Birth(REQUIRED)** 9/11/1947
Address HAUHFUIG City GYGUIGYUYIG State AR Zip 70809
Sex ☐ M ☐ F Height (Ft. In.)5' 7" Weight (Lbs.) 654 Email Address christyj@starmountlife.com
Home Phone (required) 555-555-5555 Cell or Work Phone

Are you employed? ☐ Yes ☑No (If no, explain) Occupation/Duties (If disabled, explain)
Doctor or Clinic (Full Name) gfxj Doctor is located in: City GCJGH State --
Beneficiary (Full Name) (If none listed, cash will go to your estate.) jkchykvg Relationship hjkhjvkhjv

I wish to apply for insurance in the amount of:

☑ $25000

Check one: add accidental death cash option for: ☐ **Double Benefits** ☐ **Triple Benefits** ☑ Not interested

Indicate Method of Payment

☑ Deduct future payments from my checking account automatically. (Enclose a blank check with CANCELLED written across the face.)
☐ Charge future payments to: ☐ VISA ☐ MasterCard Credit Card # Exp. Date:
☐ Bill me direct for future payments. (There is a $1 charge each month if direct billing is monthly. Billing is free if every 3 months, annually or by credit card or check draft.)

I want to pay: ☐ Annually (5% discount for annual payment) ☐ Every 3 months ☐ Monthly (We recommend annually or every 3 months.)

Health Questions

1.) Have you smoked, chewed or used tobacco in any form in the last 24 months? ☐Yes ☑No
If yes, do you smoke more than 2 packs per day? ☐ Yes ☑ No

2.) In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Cancer; tumor; polyps; stroke; kidney failure; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing?
☐ YES ☑ NO

3.) In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Mental or nervous disorder; Alzheimer's disease; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction?
☐ YES ☑ NO

4.) Have you ever (in MO, not to exceed 10 years) tested positive for exposure to (in MO & KS, have you been positively diagnosed or treated for) the HIV (Human Immunodeficiency Virus) infection or been diagnosed, as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? (If yes, list applicable ones and explain.)
☐ YES ☑ NO

5.) Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with diabetes?
☐ YES ☑ NO

6.) If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?
☐ YES ☑ NO

7.) Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with high blood pressure (In MS & OK, hypertension)?
☐ YES ☑ NO

8.) If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?

☐ YES ☑ NO

9.) In the last 5 years, have you received or been advised to receive any medical or surgical procedure or taken prescription medicine for any condition other than those noted above? (If yes, please explain.)
☐ YES ☑ NO

10.) Within the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (If yes, please describe disability.)
☐ YES ☑ NO

11.) Are you currently, or have you in the past 12 months, used or been advised to take prescription drugs? (If yes, please list medications and reason for their use.)
☐ YES ☑ NO

12.) In the past 5 years, have you had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? (If yes, list those that apply.)
☐ YES ☑ NO

13.) Will the coverage applied for replace or change any existing life insurance or annuity?

☐ YES ☑ NO

I have read the above questions and declare the answers are complete and true to the best of my knowledge and belief. I agree the answers will form a part of the policy and the insurance will not be in force until this application has been approved by the company and the policy issued and delivered to me when I am in the same health condition as described above, and the first premium paid.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has any record of me or my health to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status. Although information about drug or alcohol abuse, mental illness, and HIV and/or AIDS status may be protected by government regulation, I allow Starmount to collect it to determine insurability. I understand I (or my authorized representative) am entitled to a copy of the information obtained; that this authorization will expire in 30 months (in KS and OK, in 24 months) from the date of signature, but can be revoked at any time with the applicant's written notification. This information will be used to determine insurability. I understand that I (or my authorized representative) am entitled to receive a copy of this authorization form. A photo copy is as valid as the original. I am also aware that the records may be subject to re-disclosure by the recipient. I am aware that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See below for fraud statements specific to your state.)

Applicant's Signature: Application was Electronically Signed and Submitted **Date: 4/30/2012 9:40:09 AM**

Exclusions: Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

Fraud Statements: For residents of Arkansas and Louisiana: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

1-888-SAY-LIFE (1-888-729-5433)

STARMOUNT LIFE INSURANCE

Protect Tomorrow...by Planning Today! ®

StarLife Gold
Term Life Insurance. Protection to age 95 - your cost will not change due to age or health.

QUOTE APPLY

ValueLife Gold
Modified Whole Life Insurance. Our lowest cost option. It can last for life, even if you live to age 120!

QUOTE APPLY

ValueLife Gold

STEP ONE → STEP TWO → STEP THREE → STEP FOUR

You can access and print a copy of the application form by clicking here. You can then complete and return it to us by regular mail:

P.O. Box 98100
Baton Rouge, LA 70898-9100

OR
Fax toll-free 1-888-729-7827

OR
Call toll-free at 1-888-729-5433 and we will be happy to send the necessary materials to your home.

THE APPLICATION WILL TAKE ABOUT 5 MINUTES TO COMPLETE.
4 SCREENS ARE INCLUDED.

First Name*	
Last Name*	
Date of Birth*	Month / Day / Year
Email*	(e.g. you@somewhere.com)
Address*	
City*	
State*	Arkansas
Zip*	
Sex*	Male Female
Height*	-- Ft. -- In.
Weight*	(lbs.)
Home Phone*	(e.g. 555-555-5555)
Cell or Work Phone	(e.g. 555-555-5555)
Are you employed?*	Yes No
Occupation / Duties (Required if Employed. If disabled, explain.)	
I wish to apply for insurance in the amount of*	Choose
Add Accidental Death Cash Option for*	Double Benefits / Triple Beneftis / Not Interested
Have you smoked, chewed, or used tobacco in the last 24 months?*	Yes No
Do you smoke 2 or more packs per day? (Required if Smoked in last 12 months)	Yes No

NEXT STEP

UNI APP11-web AR-web

ValueLife Gold

STEP ONE | STEP TWO | STEP THREE | STEP FOUR

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Baton Rouge, LA 70898-9100

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Fax toll-free 1-888-729-7827

OR
Call toll-free at 1-888-729-5433, 2015 and we will be happy to send the necessary materials to your home.

MEDICAL INFORMATION

Doctor or Clinic Name*

Doctor is located in: City* State* --

Beneficiary (Full name)
(If none listed, cash will go to your estate.)

Relationship

PAYMENT INFORMATION*

Deduct future payments from my checking account automatically.

Bank Route #

Account #

Bank Name

Bank Location

OR

Charge 1¢ and future payments to: Choose One

Credit Card #

Expiration Date / (mm/yy)

I want to pay* Choose One
5% Discount for annual payments

PREVIOUS STEP NEXT STEP

UNI APP11-web AR-web

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Baton Rouge, LA 70898-9100

OR
Fax toll-free 1-888-729-7827

OR
Call toll-free at 1-888-729-5433 and we will be happy to send the necessary materials to your home.

PLEASE ANSWER THESE QUESTIONS:

*** 1. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Cancer; tumor; polyps; stroke; kidney failure; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 2. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Mental or nervous disorder; Alzheimer's disease; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 3. Have you ever (in MO, not to exceed 10 years) tested positive for exposure to (in MO & KS, have you been positively diagnosed or treated for) the HIV (Human Immunodeficiency Virus) infection or been diagnosed, as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? (If yes, list applicable ones and explain.)**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 4. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with diabetes?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 5. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 6. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with high blood pressure (In MS & OK, hypertension)?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 7. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 8. In the last 5 years, have you received or been advised to receive any medical or surgical procedure or taken prescription medicine for any condition other than those noted above? (If yes, please explain.)**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

*** 9. Within the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (If yes, please describe disability.)**

Yes (If Yes, please explain in the box below.)

No

* 10. Are you currently, or have you in the past 12 months, used or been advised to take prescription drugs? (If yes, please list medications and reason for their use.)

Yes (If Yes, please explain in the box below.)

No

* 11. In the past 5 years, have you had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? (If yes, list those that apply.)

Yes (If Yes, please explain in the box below.)

No

* 12. Will the coverage applied for replace or change any existing life insurance or annuity?

Yes (If Yes, please explain in the box below.)

No

How did you find Starmount's Web site?

An Agent

PREVIOUS STEP NEXT STEP

UNI APP11-web AR-web

ValueLife Gold

STEP ONE | STEP TWO | STEP THREE | STEP FOUR

You can access and print a copy of the application form by clicking here. You can then complete and return it to us by regular mail:

P.O. Box 98100
Baton Rouge, LA 70898-9100

OR
Fax toll-free 1-888-729-7827

OR
Call toll-free at 1-888-729-5433 and we will be happy to send the necessary materials to your home.

AUTHORIZATION AND AGREEMENT

Please read the following:

By submitting this on-line application, I acknowledge the following:

I have read the above questions and declare the answers are complete and true to the best of my knowledge and belief. I agree the answers will form a part of the policy and the insurance will not be in force until this application has been approved by the company and the policy issued and delivered to me when I am in the same health condition as described above, and the first premium paid.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has any record of me or my health to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status. Although information about drug or alcohol abuse, mental illness, and HIV and/or AIDS status may be protected by government regulation, I allow Starmount to collect it to determine insurability. I understand I (or my authorized representative) am entitled to a copy of the information obtained; that this authorization will expire in 30 months (in KS and OK, in 24 months) from the date of signature, but can be revoked at any time with the applicant's written notification. This information will be used to determine insurability. I understand that I (or my authorized representative) am entitled to receive a copy of this authorization form. A photo copy is as valid as the original. I am also aware that the records may be subject to re-disclosure by the recipient. I am aware that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See below for fraud statements specific to your state.)

Fraud Statements: For residents of Arkansas and Louisiana: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

Exclusions: Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

☐ **Check to sign this application as the Main Insured.**

PREVIOUS STEP NEXT STEP

UNI APP11-web AR-web

ValueLife Gold

REVIEW

Review

Last Name	Doe
First Name	John
Email	christyj@starmountlife.com
Address	hauhfuig
City	gyguigyuyig
State	AR
Zip	70809
Amount of Coverage	$25000
Accidental Death Cash Option	None
Sex	Male
Have you smoked, chewed, or used tobacco in the last 24 months?	No
Do you smoke 2 or more packs per day?	No
Date of birth	9/11/1947
Height	5Ft. 7In.
Weight	654
Employed	No
Occupation / Duties	
Home Phone	555-555-5555
Cell or Office Phone	
Doctor's Name	gfxj
Doctor's City	gcjgh
Doctor's State	--
Beneficiary (Full name)	jkchykvg
Relationship	hjkhjvkhjv
Payment Type	Bank Account
Bank Route #	064208165
Account #	546461425
Bank Name	gygyuf
Bank Location	yftyfyigfyuui
Billing Frequency	SemiAnnual
1. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Cancer; tumor; polyps; stroke; kidney failure; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing?	No
Explanation	
2. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Mental or nervous disorder; Alzheimer's disease; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction?	No
Explanation	
3. Have you ever (in MO, not to exceed 10 years) tested positive for exposure to (in MO & KS, have you been positively diagnosed or treated for) the HIV (Human Immunodeficiency Virus) infection or been diagnosed, as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? (If yes, list applicable ones and explain.)	No
Explanation	
4. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with diabetes?	No
Explanation	

5. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?	No
Explanation	
6. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with high blood pressure (In MS & OK, hypertension)?	No
Explanation	
7. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?	No
Explanation	
8. In the last 5 years, have you received or been advised to receive any medical or surgical procedure or taken prescription medicine for any condition other than those noted above? (If yes, please explain.)	No
Explanation	
9. Within the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (If yes, please describe disability.)	No
Explanation	
10. Are you currently, or have you in the past 12 months, used or been advised to take prescription drugs? (If yes, please list medications and reason for their use.)	No
Explanation	
11. In the past 5 years, have you had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? (If yes, list those that apply.)	No
Explanation	
12. Will the coverage applied for replace or change any existing life insurance or annuity?	No
Explanation	

Submit Application Previous Step

UNI APP11-web AR-web

Application for Life Insurance

Starmount Life Insurance Co. • 8485 Goodwood Blvd. • Baton Rouge, LA 70806-7878 • 1-888-729-5433 •
www.TermLifeToAge95.com

For Term Life Insurance Policy No.21-001; Accidental Death Rider Form No. 97005; Accelerated Benefit Rider 98-010

Main Insured Information

Name John Doe **Date of Birth(REQUIRED)** 7/10/1939
Address HAIFH City GUGUGYGHUK State AR Zip 70809
Sex ☐ M ☐ F Height (Ft. In.)2' 3" Weight (Lbs.) 15 Email Address christyj@starmountlife.com
Home Phone (required) 555-555-5555 Cell or Work Phone

Are you employed? ☐ Yes ☑No (If no, explain) Occupation/Duties (If disabled, explain)
Doctor or Clinic (Full Name) gfdjx Doctor is located in: City TGHJKGHK State AR
Beneficiary (Full Name) (If none listed, cash will go to your estate.) kgvljkl;h Relationship bjklgjl

I wish to apply for insurance in the amount of:

☑ $15000

Check one: add accidental death cash option for: ☐ **Double Benefits** ☐ **Triple Benefits** ☑ Not interested

Indicate Method of Payment

☑ Deduct future payments from my checking account automatically. (Enclose a blank check with CANCELLED written across the face.)
☐ Charge future payments to: ☐ VISA ☐ MasterCard Credit Card # Exp. Date:
☐ Bill me direct for future payments. (There is a $1 charge each month if direct billing is monthly. Billing is free if every 3 months, annually or by credit card or check draft.)

I want to pay: ☐ Annually (5% discount for annual payment) ☐ Every 3 months ☑ Monthly (We recommend annually or every 3 months.)

Health Questions

1.) Have you smoked, chewed or used tobacco in any form in the last 24 months? ☐Yes ☑No
If yes, do you smoke more than 2 packs per day? ☐ Yes ☑ No

2.) In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Cancer; tumor; polyps; stroke; kidney failure; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing?
☐ YES ☑ NO

3.) In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Mental or nervous disorder; Alzheimer's disease; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction?
☐ YES ☑ NO

4.) Have you ever (in MO, not to exceed 10 years) tested positive for exposure to (in MO & KS, have you been positively diagnosed or treated for) the HIV (Human Immunodeficiency Virus) infection or been diagnosed, as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? (If yes, list applicable ones and explain.)
☐ YES ☑ NO

5.) Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with diabetes?
☐ YES ☑ NO

6.) If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?
☐ YES ☑ NO

7.) Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with high blood pressure (In MS & OK, hypertension)?
☐ YES ☑ NO

8.) If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?

☐ YES ☑ NO

9.) In the last 5 years, have you received or been advised to receive any medical or surgical procedure or taken prescription medicine for any condition other than those noted above? (If yes, please explain.)
☐ YES ☑ NO

10.) Within the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (If yes, please describe disability.)
☐ YES ☑ NO

11.) Are you currently, or have you in the past 12 months, used or been advised to take prescription drugs? (If yes, please list medications and reason for their use.)
☐ YES ☑ NO

12.) In the past 5 years, have you had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? (If yes, list those that apply.)
☐ YES ☑ NO

13.) Will the coverage applied for replace or change any existing life insurance or annuity?

☐ YES ☑ NO

I have read the above questions and declare the answers are complete and true to the best of my knowledge and belief. I agree the answers will form a part of the policy and the insurance will not be in force until this application has been approved by the company and the policy issued and delivered to me when I am in the same health condition as described above, and the first premium paid.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has any record of me or my health to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status. Although information about drug or alcohol abuse, mental illness, and HIV and/or AIDS status may be protected by government regulation, I allow Starmount to collect it to determine insurability. I understand I (or my authorized representative) am entitled to a copy of the information obtained; that this authorization will expire in 30 months (in KS and OK, in 24 months) from the date of signature, but can be revoked at any time with the applicant's written notification. This information will be used to determine insurability. I understand that I (or my authorized representative) am entitled to receive a copy of this authorization form. A photo copy is as valid as the original. I am also aware that the records may be subject to re-disclosure by the recipient. I am aware that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See below for fraud statements specific to your state.)

Applicant's Signature: Application was Electronically Signed and Submitted **Date: 4/30/2012 9:36:39 AM**

Exclusions: Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

Fraud Statements: For residents of Arkansas and Louisiana: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime and may be subject to fines and confinement in prison.

1-888-SAY-LIFE (1-888-729-5433)

STARMOUNT LIFE INSURANCE

Protect Tomorrow...by Planning Today! ®

StarLife Gold
Term Life Insurance. Protection to age 95 - your cost will not change due to age or health.

QUOTE APPLY

ValueLife Gold
Modified Whole Life Insurance. Our lowest cost option. It can last for life, even if you live to age 120!

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STEP ONE | STEP TWO | STEP THREE | STEP FOUR

You can access and print a copy of the application form by clicking here. You can then complete and return it to us by regular mail:

P.O. Box 98100
Baton Rouge, LA 70898-9100

OR
Fax toll-free 1-888-729-7827

OR
Call toll-free at 1-888-729-5433 and we will be happy to send the necessary materials to your home.

THE APPLICATION WILL TAKE ABOUT 5 MINUTES TO COMPLETE.
4 SCREENS ARE INCLUDED.

First Name*	
Last Name*	
Date of Birth*	Month / Day / Year
Email*	(e.g. you@somewhere.com)
Address*	
City*	
State*	Arkansas
Zip*	
Sex*	Male Female
Height*	-- Ft. -- In.
Weight*	(lbs.)
Home Phone*	(e.g. 555-555-5555)
Cell or Work Phone	(e.g. 555-555-5555)
Are you employed?*	Yes No
Occupation / Duties (Required if Employed. If disabled, explain.)	
I wish to apply for insurance in the amount of*	Choose
Add Accidental Death Cash Option for*	Double Benefits / Triple Beneftis / Not Interested
Have you smoked, chewed, or used tobacco in the last 24 months?*	Yes No
Do you smoke 2 or more packs per day? (Required if Smoked in last 12 months)	Yes No

NEXT STEP

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MEDICAL INFORMATION

Doctor or Clinic Name*

Doctor is located in: City* State* --

Beneficiary (Full name)
(If none listed, cash will go to your estate.)

Relationship

PAYMENT INFORMATION*

Deduct future payments from my checking account automatically.

Bank Route #

Account #

Bank Name

Bank Location

OR

Charge $1 and future payments to: Choose One

Credit Card #

Expiration Date / (mm/yy)

I want to pay* Choose One
5% Discount for annual payments

PREVIOUS STEP NEXT STEP

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Baton Rouge, LA 70898-9100

OR
Fax toll-free 1-888-729-7827

OR
Call toll-free at 1-888-729-5433 and we will be happy to send the necessary materials to your home.

PLEASE ANSWER THESE QUESTIONS:

* **1. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Cancer; tumor; polyps; stroke; kidney failure; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **2. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Mental or nervous disorder; Alzheimer's disease; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **3. Have you ever (in MO, not to exceed 10 years) tested positive for exposure to (in MO & KS, have you been positively diagnosed or treated for) the HIV (Human Immunodeficiency Virus) infection or been diagnosed, as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? (If yes, list applicable ones and explain.)**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **4. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with diabetes?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **5. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **6. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with high blood pressure (In MS & OK, hypertension)?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **7. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **8. In the last 5 years, have you received or been advised to receive any medical or surgical procedure or taken prescription medicine for any condition other than those noted above? (If yes, please explain.)**

- ○ Yes (If Yes, please explain in the box below.)
- ○ No

* **9. Within the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (If yes, please describe disability.)**

Yes (If Yes, please explain in the box below.)

No

* 10. Are you currently, or have you in the past 12 months, used or been advised to take prescription drugs? (If yes, please list medications and reason for their use.)

Yes (If Yes, please explain in the box below.)

No

* 11. In the past 5 years, have you had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? (If yes, list those that apply.)

Yes (If Yes, please explain in the box below.)

No

* 12. Will the coverage applied for replace or change any existing life insurance or annuity?

Yes (If Yes, please explain in the box below.)

No

How did you find Starmount's Web site?

An Agent

PREVIOUS STEP NEXT STEP

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STEP ONE | STEP TWO | STEP THREE | STEP FOUR

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OR
Call toll-free at 1-888-729-5433 and we will be happy to send the necessary materials to your home.

AUTHORIZATION AND AGREEMENT

Please read the following:

By submitting this on-line application, I acknowledge the following:

I have read the above questions and declare the answers are complete and true to the best of my knowledge and belief. I agree the answers will form a part of the policy and the insurance will not be in force until this application has been approved by the company and the policy issued and delivered to me when I am in the same health condition as described above, and the first premium paid.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager or other medical related facility, insurance company, family member, the Medical Information Bureau, or other organization or person, that has any record of me or my health to give Starmount Life Insurance Company, my legal representative for medical records receipt, or its reinsurers, any such information. This includes knowledge about drug abuse, alcoholism or mental illness, and HIV (Human Immunodeficiency Virus) and/or AIDS (Acquired Immune Deficiency Syndrome) status. Although information about drug or alcohol abuse, mental illness, and HIV and/or AIDS status may be protected by government regulation, I allow Starmount to collect it to determine insurability. I understand I (or my authorized representative) am entitled to a copy of the information obtained; that this authorization will expire in 30 months (in KS and OK, in 24 months) from the date of signature, but can be revoked at any time with the applicant's written notification. This information will be used to determine insurability. I understand that I (or my authorized representative) am entitled to receive a copy of this authorization form. A photo copy is as valid as the original. I am also aware that the records may be subject to re-disclosure by the recipient. I am aware that re-disclosed information may no longer be protected by federal privacy regulations. I acknowledge receipt of the MIB Disclosure Notice. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. (See below for fraud statements specific to your state.)

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Exclusions: Exclusions may apply. Please see your policy for limitations and exclusions specific to your state.

☐ **Check to sign this application as the Main Insured.**

PREVIOUS STEP NEXT STEP

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StarLife Gold

REVIEW

Review

Last Name	Doe
First Name	John
Email	christyj@starmountlife.com
Address	haifh
City	gugugyghuk
State	AR
Zip	70809
Amount of Coverage	$15000
Accidental Death Cash Option	None
Sex	Male
Have you smoked, chewed, or used tobacco in the last 24 months?	No
Do you smoke 2 or more packs per day?	No
Date of birth	7/10/1939
Height	2Ft. 3In.
Weight	15
Employed	No
Occupation / Duties	
Home Phone	555-555-5555
Cell or Office Phone	
Doctor's Name	gfdjx
Doctor's City	tghjkghk
Doctor's State	AR
Beneficiary (Full name)	kgvljkl;h
Relationship	bjkljgjl
Payment Type	Bank Account
Bank Route #	064208165
Account #	2644
Bank Name	vcxnhjgfjm
Bank Location	cjghjth
Billing Frequency	Monthly
1. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Cancer; tumor; polyps; stroke; kidney failure; hepatitis; any disease or disorder of the kidneys, heart, blood, liver or circulatory system; any chronic respiratory or lung disorder; or used oxygen to assist in breathing?	No
Explanation	
2. In the past 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or diagnosed with any of the following conditions: (List each condition and explain all yes answers.) Mental or nervous disorder; Alzheimer's disease; dementia; alcoholism; drug addiction; taken illegal drugs; abused prescription medication; been ticketed for DWI or DUI or had a felony conviction?	No
Explanation	
3. Have you ever (in MO, not to exceed 10 years) tested positive for exposure to (in MO & KS, have you been positively diagnosed or treated for) the HIV (Human Immunodeficiency Virus) infection or been diagnosed, as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection? (If yes, list applicable ones and explain.)	No
Explanation	
4. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with diabetes?	No
Explanation	

5. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?	No
Explanation	
6. Within the last 5 years, have you been told (in KS, by a qualified medical professional) you had, been treated for, or been diagnosed with high blood pressure (In MS & OK, hypertension)?	No
Explanation	
7. If yes, are you scheduling regular check-up visits and taking medication as prescribed by your physician?	No
Explanation	
8. In the last 5 years, have you received or been advised to receive any medical or surgical procedure or taken prescription medicine for any condition other than those noted above? (If yes, please explain.)	No
Explanation	
9. Within the last 12 months, have you received or applied for Social Security Disability, Supplemental Security Income, Worker's Compensation, any other disability benefits, or are you disabled? (If yes, please describe disability.)	No
Explanation	
10. Are you currently, or have you in the past 12 months, used or been advised to take prescription drugs? (If yes, please list medications and reason for their use.)	No
Explanation	
11. In the past 5 years, have you had an application for life or health insurance rated, postponed, modified or declined (declined, not applicable in MO)? (If yes, list those that apply.)	No
Explanation	
12. Will the coverage applied for replace or change any existing life insurance or annuity?	No
Explanation	

Submit Application Previous Step

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SERFF Tracking Number:	*STAR-128295543*	*State:*	*Arkansas*
Filing Company:	*Starmount Life Insurance Company*	*State Tracking Number:*	
Company Tracking Number:			
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*Website APP for UNI APP11*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Flesch Certification
Bypass Reason: N/A- this is a website application.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: See filing description.
Comments: